N321 Care Plan #1

Lakeview College of Nursing

Sophia James

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
6-4-22	JC	57	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Not currently employed	Divorced	Cat Dander
Code Status	**Height**	**Weight**	
Full	5’9’’	79 kg	

BMI: 25.71

Medical History (5 Points)

Past Medical History: Alcoholism 10/13/2017 Cocaine abuse 12/21/2018

Sleep Apnea (CPAP) Liver damage (hepatic clot)

Acute renal failure (N/A)

Past Surgical History: Left Leg amputation below the knee 1974 - car accident

Upper gastrointestinal endoscopy 2017 Liver surgery 2019 (cancer)

Family History: No family members were listed.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use):

Alcoholic - stopped January 2022. Current nicotine smoker - pipe, chew for 33 years. About half a pack a day.

Assistive Devices: The patient has glasses. Sleeps with CPAP. Left leg amputee prosthetic

Living Situation: None listed. Lives at home when asked. The patient is divorced.

Education Level: completed High School

Admission Assessment

Chief Complaint (2 points): Bright red vomit

History of Present Illness – OLD CARTS (10 points):

O: Onset- started two weeks ago

L: Location- Upper gastrointestinal region

D: Duration- two weeks ago to current. The last episode was on 6/6/22 at 0400.

C: Characteristics- Previously was bright red emesis. The last episode was coffee ground emesis.

A: Associated factors- Nausea, stomach RUQ pain

R: Resolutions- Sleep, tums

T: Treatment- Tums help the nausea

The patient was admitted to the hospital on June 4, 2022. The patient's chief complaint consisted of bright red vomit that started two weeks ago from the date. The location is in the upper gastrointestinal region. This has lasted for two weeks to the present, and the last episode was on June 6, 2022, at 0400. The patient stated that it was previously bright red emesis, but the last episode was dark brown "coffee ground" emesis. Associated factors with this chief complaint are nausea and right upper quadrant/stomach pain. The pain is due to previous liver cirrhosis found in 2019. The patient stated that sleep and Tums help with nausea and symptoms.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hematemesis

Secondary Diagnosis (if applicable): Liver cirrhosis

Pathophysiology of the Disease, APA format (20 points):

Hematemesis is most commonly seen caused by an upper gastrointestinal bleed. “G.I. bleeding is defined as hemorrhage from the mouth to the ligament of Treitz.” (Wilkins 2020). The most common causes of upper G.I. bleeding include peptic ulcer bleeding, gastritis, esophagitis, variceal bleeding, and cancer. “Physical examinations include assessment of hemodynamic stability, presence of abdominal pain or rebound tenderness, and an examination

of stool and emesis color." (Wilkins 2020). Patients who have hematemesis most likely will get an endoscopy done. An endoscopy is a procedure where the patient is put under anesthesia and the provider goes down into the patient's upper gastrointestinal tract to see where the bleeding is coming from. Hematemesis is defined as blood in the vomit. Most of the time it looks like coffee grounds and is a deep brown-reddish color.

Hematemesis is often treated by medication such as anti-acids to help with nausea and having an endoscopy procedure done. After the endoscopy is performed, the provider will hopefully be able to see what was causing the bleeding and be able to fix it. Most of the time it is seen as variceal bleeding. Variceal bleeding is when the veins in the esophagus get inflamed and burst open. Most likely the doctor will wrap elastic bands around the varices during the endoscopy and help stop the bleeding.

Variceal bleeding can also happen in the liver. This is most likely caused by liver cirrhosis. Liver cirrhosis may be a side effect of chronic liver disease causing scar tissue to cover the liver and inhibiting it to work properly. Symptoms of this can be jaundice, vomiting blood, tarry-looking stool, ascites, and more.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [CoursePoint]. Retrieved from https://coursepoint.vitalsource.com/#/books/9781719641470/

Wilkins, T., Wheeler, B., & Carpenter, M. (2020). Upper Gastrointestinal Bleeding in Adults: Evaluation and Management. *American family physician*, *101*(5), 294–300.

Laboratory Data (15 points) CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value

RBC	**4.2-5.4**	**3.53**	**N/A**	**This patient is diagnosed with anemia which is the cause for the low RBC count. (Capriotti 2020)**
Hgb	**12-16**	**11.2**	**10.3**	**This patient is diagnosed with anemia which is the cause for the low Hgb count. (Capriotti 2020)**
Hct	**37-47**	**33.7**	**31.9**	**This patient is diagnosed with anemia which is the cause for the low Hct count. (Capriotti 2020)**
Platelets	**150-400**	**127**	**114**	**This patient has low platelet count. The patient is also taking heparin which could be the cause of the low count. (Capriotti 2020)**
WBC	**4.5-11.0**	**7.19**	**6.55**	**WBC was within moral limits.**
Neutrophils	**55-70**	**N/A**	**N/A**	**Neutrophils are within normal limits.**
Lymphocytes	**20-40**	**12.2**	**N/A**	**The patient's lymphocyte levels were lower than normal. This could be due to the liver damage he is and has been experiencing. (Capriotti 2020)**
Monocytes	**2-8**	**11.4**	**N/A**	**High monocyte levels can be due to infection or recovering from infection. This patient does have liver issues and acute kidney failure. This patient was also vomiting which could lead to the high monocyte level. (Capriotti 2020)**
Eosinophils	**1-4**	**6.5**	**N/A**	**Eosinophils are higher than the normal limits. Too much stress on the body can increase these levels. The patient has been vomiting and has varices which could be the cause of the higher levels and the stress of the body. (Capriotti 2020)**
Bands	**0-5**	**N/A**	**N/A**	**Bands were within the normal limits.**

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	135	135	Sodium is within normal limits.
K+	3.5-5	4.3	4.6	Potassium is within normal limits.
Cl-	98-106	100	102	Chlorine is within normal limits.
CO2	23-30	23.0	22.0	Carbon Dioxide was slightly lower than normal. This could be because the body could be in diabetic ketoacidosis which is when the blood acid level goes up because there's not enough insulin to digest the sugars. This could relate to the patient due to him being pre-diabetic. (Capriotti 2020)
Glucose	60-120	152	90	Glucose was above the normal range. This is due to the patient being a Pre-diabetic. It went down during his stay at the hospital because he was probably watching his diet more closely. (Capriotti 2020)
BUN	10-20	16	17	BUN is within normal limits.
Creatinine	0.5-0.8	1.56	1.37	This patient did have acute renal failure which impairs kidney function. Creatinine can rise due to this impaired function of the kidney. (Capriotti 2020)
Albumin	3.5-5	3.4	3.4	Albumin is made by the liver. This patient has liver cirrhosis which would be the cause for the low albumin levels. (Capriotti 2020)
Calcium	9-11	10.1	9.1	Calcium is within normal limits.

Mag	**1.3-2.1**	**N/A**	**N/A**	**Mag is within normal limits.**
Phosphate	**3.0-4.5**	**N/A**	**N/A**	**Phosphate is within normal limits.**
Bilirubin	**0.3-1**	**0.9**	**0.9**	**Bilirubin is within normal limits.**
Alk Phos	**30-120**	**80**	**80**	**Alk Phos is within normal limits.**
AST	**10-30**	**29**	**29**	**AST is within normal limits.**
ALT	**10-40**	**16**	**16**	**ALT is within normal limits.**
Amylase	**23-85**	**42**	**42**	**Amylase is within normal limits.**
Lipase	**0-160**	**18**	**18**	**Lipase is within normal limits.**
Lactic Acid	**<2**	**N/A**	**N/A**	**Lactic Acid is within normal limits.**

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**1-3**	**1.3**	**1.3**	**INR is within normal limits.**
PT	**12-16**	**15.7**	**N/A**	**PT is within normal limits.**
PTT	**30-55**	**36.0**	**N/A**	**PTT is within normal limits.**
D-Dimer	**<0.50**	**N/A**	**N/A**	**D-Dimer is within normal limits.**
BNP	**<100**	**N/A**	**N/A**	**BNP is within normal limits.**
HDL	**>60**	**N/A**	**N/A**	**HDL is within normal limits.**
LDL	**<130**	**N/A**	**N/A**	**LDL is within normal limits.**
Cholesterol	**200**	**N/A**	**N/A**	**Cholesterol is within normal limits.**
Triglycerides	**<150**	**N/A**	**N/A**	**Triglycerides are within normal limits.**
Hgb A1c	**4-6**	**5.2**	**N/A**	**Hgb A1c is within normal limits.**

TSH	**0.5-5.0**	**4.190**	**N/A**	**TSH is within normal limits.**

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Clear Yellow**	**N/A**	**N/A**	**N/A**
pH	**4.6-8**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.005-1.030**	**N/A**	**N/A**	**N/A**
Glucose	**Negative**	**N/A**	**N/A**	**N/A**
Protein	**0-8**	**N/A**	**N/A**	**N/A**
Ketones	**Negative**	**N/A**	**N/A**	**N/A**
WBC	**Negative**	**N/A**	**N/A**	**N/A**
RBC	**Negative**	**N/A**	**N/A**	**N/A**
Leukoesterase	**Negative**	**N/A**	**N/A**	**N/A**

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative < 10,000 Postive > 100,000**	**N/A**	**N/A**	**Abnormal urine culture may indicate a UTI or bladder infection. (Capriotti, 2022)**
Blood Culture	**Negative**	**N/A**	**N/A**	**If there is a positive blood culture this means there is an infection or bacteria in the blood. (Capriotti, 2022)**
Sputum Culture	**Normal URT**	**N/A**	**N/A**	**Abnormal septum culture will**

				indicate a fungal infection within the body. (Capriotti, 2022)
Stool Culture	**Normal Intestinal Flora**	**N/A**	**N/A**	**Abnormal stool culture will indicate a disease or cancer in the body. (Capriotti, 2022)**

Lab Correlations Reference (1) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [CoursePoint]. Retrieved from https://coursepoint.vitalsource.com/#/books/9781719641470/

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient will have an Endoscopy and Colonoscopy tomorrow (6/7/22).

Diagnostic Test Correlation (5 points): During the endoscopy and colonoscopy, the provider will be able to see where the emesis is coming from. An endoscopy can view disorders in the upper GI tract, such as a bleeding disorder (Capriotti, 2020). On the other hand, a colonoscopy should be done to investigate the lower Gi tract to examine any bleeding or polyps. (Capriotti 2020)

Diagnostic Test Reference (1) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [CoursePoint]. Retrieved from https://coursepoint.vitalsource.com/#/books/9781719641470/

Current Medications (10 points, 1 point per completed med)
***10 <u>different</u> medications must be completed* Home Medications (5 required)**

Brand/ Generic	**amitriptyline Elavil**	**Folic Acid**	**Calcium carbonate Tablet Tums**	**Ferrous sulfate**	**Thiamine**
Dose	**10mg**	**1mg**	**1000mg**	**324mg**	**100mg**
Frequency	**Daily at bed time**	**Twice daily**	**PRN**	**Twice daily**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Antidepressant**	**Vitamins, Water-soluble**	**Calcium salts, anti-acid, anti-hyper phosphatemic, calcium replacement cardiotonic**	**Hematinic, antianemic, nutritional supplement.**	**Vitamins**

Mechanism of Action	**Amitriptyline blocks serotonin and norepinephrine reuptake by adrenergic nerves. By doing so, it raises serotonin and norepinephrine levels at nerve synapses. This action elevates mood and reduces depression.**	**Folic acid is an essential nutrient necessary for proteins and nucleic acid synthesis. Folic acid is synthesized by bacteria from the substrate, para amino benzoic acid.**	**Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal system.**	**Acts to normalize red blood cell production by binding with hemoglobin or by being oxidized being stored in the bone marrow, liver, and spleen.**	**Thiamine combines with ATP in the liver, kidneys, and leukocytes to produce thiamine diphosphate. This plays a role in growth and function for the cells.**
Reason Client Taking	**Mood stabilizer**	**B vitamin to help make new cells.**	**Nausea**	**Iron deficiency, Anemic**	**B vitamin for cell growth and supplement**
Contraindications (2)	**Acute recovery phase after MI, concurrent therapy with cisapride, hypersensitivity to amitriptyline or its components.**	**Pernicious anemia, pregnancy, breast-feeding, Renal disease**	**Cardiac resuscitation with risk of existing digitalis toxicity or presence of ventricular fibrillation. Frequent use of calcium supplements or calcium salts.**	**Hemochromatosis, hemolytic anemias, hemosiderosis, hypersensitivity to iron salts or their components.**	**Any allergy to vitamin supplements and any contradictions to thiamine.**
Side Effects/	**Anxiety, ECG**	**Confusio**	**Nausea or**	**Chest pain,**	**Weakness,**

Adverse Reactions (2)	**changes, orthostatic hypotension, abdominal cramps**	**n, seizures, diarrhea, behavior changes**	**vomiting, hypotension or irregular heartbeat.**	**chills, dizziness, fever, metallic taste.**	**nausea, restlessness, itchiness**
Nursing Considerations (2)	**Closely monitor patient with CV disorder because amitriptyline may cause arrhythmia's such as sinus tachycardia. Monitor blood pressure for hypo or hyper tension.**	**Women who are planning a pregnancy should be advised to take folic acid daily before conception to prevent neural tube defects. Vitamin B12 levels should also be tested before giving.**	**Be aware that patience with kidney failure on dialysis may develop hypercalcemia when treated with calcium. Monitor serum calcium level and all patient as ordered and evaluate therapeutic response by assessing Chvostek's and Trousseau's sign.**	**Be aware that unabsorbed iron turns stool black or green and can mask blood in stool. Be aware that at usual dosages, serum hemoglobin level usually normalizes in about two months unless blood loss continues. Treatment may last for 3 to 6 months to help replenish iron stores.**	**Assess if your patient has a kidney disease. Monitor patient's diet and reaction.**

Hospital Medications (5 required)

Brand/ Generic	**Bisacodyl Dulcolax**	**Nicotine Nicoderm**	**Polyethylene glycol 3350 Miralax**	**Heparin injection**	**Magnesium L-lactate Mag-Tab SR)**
Dose	**10mg**	**21mg**	**119g**	**5000 units**	**84mg**
Frequency	**Daily**	**24 hr 1 patch**	**One time**	**Every 8 hours**	**Daily**
Route	**Oral**	**Transdermal**	**Oral powder**	**Subcutaneous**	**Oral**

Classification	**Laxatives**	**Smoking deterrent agent**	**Laxatives**	**Anticoagulant**	
Mechanism of Action	**Works by stimulating enteric neurons to cause peristalsis.**	**Banh selectively to Nicotinic-cholinergic receptors at autonomic ganglia, and the adrenal medulla, at neuromuscular junction, and in the brain.**	**This drug works by causing water to be retained in the stool decreasing constipation and increasing the amount of bowel movement.**	**Binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin and factors Xa and XIa.**	**Competitively blocking intracellular calcium channels and decreasing calcium availability.**
Reason Client Taking	**Prep for a colonoscopy**	**Current smoker 33 years. Withdrawal symptoms at hospital due to no smoking.**	**Prep for colonoscopy**	**Help thin the blood**	**Reducing nausea and stomach upset**
Contraindications (2)	**Patients with IBS should not be taking this drug. This drug may cause severe abdominal pain and should not be used if one has appendicitis.**	**Hypersensitivity to nicotine or it's components that's including methanol or soy. Be aware of how much a patient uses.**	**This drug may cause low calcium in the blood and low amount of sodium in the blood.: Inflammation is caused by a toxic amount of this drug.**	**Breastfeeding, infants, pregnant women**	**Anticoagulants effect magnesium. Clotting might increase. Also can cause a hormone imbalance.**

Side Effects/ Adverse Reactions (2)	**Nausea, vomiting, diarrhea, cramps, confusion, irregular heartbeat**	**Dizziness dream disturbance difficulty speaking hypertension**	**Abdominal discomfort, excessive gas, nausea**	**Chills, dizziness, fever, headache, peripheral neuropathy.**	**Diarrhea, vomiting, nausea, confusion, dizziness**
Nursing Considerations (2)	**Nurses should evaluate the therapeutic response which is decreased constipation. Nurses should discontinue if there is bleeding or severe cramping.**	**Know that drug should be used with caution in patients with hyperthyroidism and insulin-dependent diabetes. Use caution when nicotine is given with patients with active gastric or peptic ulcers or have esophagitis because nicotine delays healing in ulcer diseases.**	**Nurses should stop this drug if diarrhea occurs for more than a week. Nurses should also evaluate the therapeutic effect.**	**Ensure dose and therapeutic effect. Watch for excessive bleeding for injury/reaction.**	**Ensure vitals are done. Ensure urinary output.**

Medications Reference (1) (APA):

Jones & Bartlett Learning., & Jones & Bartlett Publishers. (2022). Nurse's drug handbook. Sudbury, MA: Jones and Bartlett Publishers.

Assessment Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Appears alert and oriented x4. Well groomed no distress
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Skin color is normal, warm, and dry. Skin is intact with no discoloration. Skin turgor is quick to return. There are no noted rashes, bruises, or wounds. Braden score= 21 There are no drains present. Patient has left leg below the knee amputated.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical trachea is midline without deviation, thyroid is non-palpable no nodules are noted bilateral carotid pulses are palpable +2. PERRLA is intact bilaterally. EOMs are intact bilaterally. eyes are clear. Patient does wear glasses. Detention looks good. Ears and nose are within normal limits.

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Heart sounds are clear, no S3, S4, or murmurs noted. Peripheral pulses are a +2 bilaterally. Capillary refill is less than three seconds bilaterally on all extremities. There is no neck vein distention, and no edema noted.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	There is no accessory muscle use, breath sounds are clear throughout bilaterally. Respirations are a normal rate and rhythm. No wheezes crackles or rhonchi noted.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Patient's current diet is clear liquid. Patient's diet at home is normal but is pre-diabetic. No insulin is needed, just monitor diet. Height- 5’9’’ weight- 79kg Bowel sounds were heard and all four quadrants. Last bowel movement was 6– 5–22. Upon palpation there was no pain in the abdomen. Distention of the abdomen is noted. No incision scars drains or wounds noted. There is no ostomy no feeding tube and no nasogastric.

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Urine was a pale yellow. no pain with urination. patient is not on dialysis. patient has no catheter.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	ROM is normal. Patient has left leg paresthetic. Strength is equal on all extremities. ADL assistance is not needed. Patient is a fall risk. Fall score-8 Patient does not need support to stand and is independent.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	PERRLA is intact strength is equal an arms and leg. Patient is alert and oriented X4. Mental status, speech, sensory, LOC is all within normal limits. Glasgow coma scale -15
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient said he believed in God. Patient is divorced, did not talk about kids, and has his mother as an emergency contact.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	66	123/63	16	97.7	97
1125	59	147/70	16	97.1	100

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Number	N/a	0	N/a	None
1125	Number	N/a	0	N/a	None

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV: left hand** **Date on IV: 6/5/22** **Patency of IV: normal** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: clean and intact**	0.9% saline- normal saline

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1880	**1760**

Nursing Care

Summary of Care (2 points)

Overview of care: In the morning, the patient's vitals were stable and he was in no pain. He was NPO till noon since the nursing staff was unsure when his procedure was going to be. The patient was alert and oriented X4 and was independent. The patient did not complain of any pain and bathed independently.

Procedures/testing done: There were no procedures or testing done during the clinical time.

Complaints/Issues: Over the whole shift, the client did not complain about any pain or issues. The only complaint was that he wanted a nicotine patch and he did receive one.

Vital signs (stable/unstable): All vital signs were stable. No pain.

Tolerating diet, activity, etc.: The patient was very aware of a clear liquid diet. Was NPO for most of the morning, but ate right away when he came off.

Physician notifications: physician stated to have client go and NPO for upcoming endoscopy and colonoscopy. Monitor laxative treatments and pain level.

Future plans for client: Patient is expected to have endoscopy and colonoscopy tomorrow 6 – 7–22.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Endoscopy and colonoscopy tomorrow 6/7/22

Education needs: Education on tomorrow's treatments.

Nursing Diagnosis (15 points)
Must be NANDA-approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. Risk for deficient fluid volume related to hematemesis as evidence by constant vomit with blood in a coffee ground appearance.	**This intervention was chosen due to the client having blood in his vomit for the past two weeks. This will lead to significant electrolyte and fluid volume loss.**	**1. Monitor and record vital signs every two hours or as often as necessary until stable. Then monitor and record vital signs every four hours. Tachycardia, dyspnea, and hypotension may indicate fluid volume deficit or an electrolyte imbalance.** **2. Measure and take an output every 1 to 4 hours. Record and reports significant changes. Include urine, stools, vomitus, wound drainage, nasogastric drainage, chest tube drainage, and any other output. Low urine output and high specific gravity indicates hypovolemia.**	**1. Patience fluid volume remains adequate.**	**Client was acceptable and responded to the interventions the nurse implemented.**

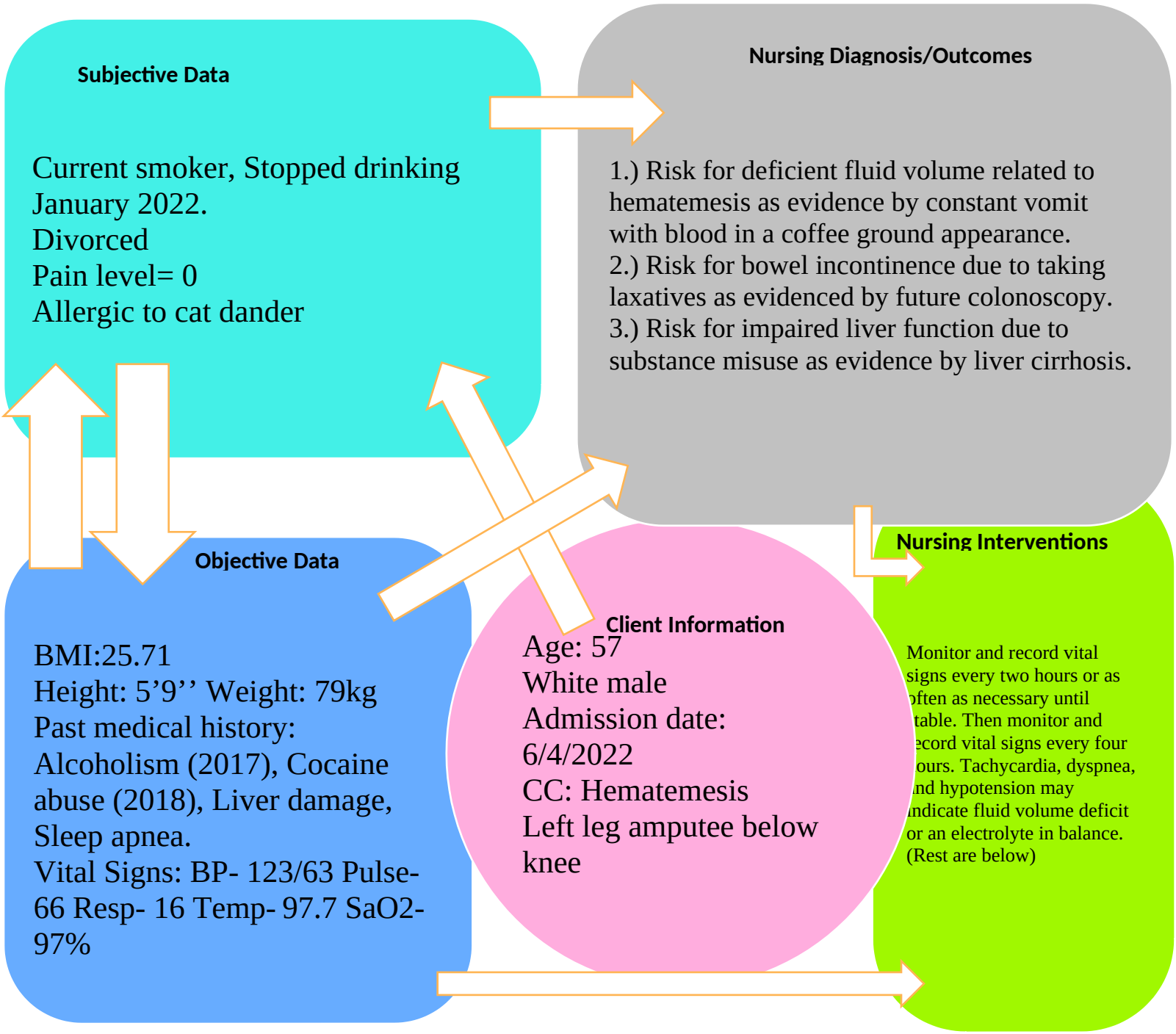
2. Risk for bowel incontinence due to taking laxatives as evidence by future colonoscopy.	**This intervention was chosen due to the patient receiving a colonoscopy in the future and also the fact that he is an amputee which can limit how fast he'll be able to get to the bathroom.**	**1. Establishing a routine time for him to get up and use the bathroom.** **2. Encouraging the client to be aware and responsive to possible incontinent episodes and the acceptance of the bowel movement routine.**	**1. To inform the patient about the medication he is taking and the risk for bowel incontinence. The outcome goal would be for him to realize he should use the bathroom more often.**	**The patient was able to agree to use the bathroom regularly in order to decrease the risk of bowel incontinence. The patient understood the medication he was on for his upcoming colonoscopy and that it would make him have to use the bathroom more.**

3. Risk for impaired liver function do to substance misuse as evidence by liver cirrhosis.	**This intervention was chosen due to the fact that this patient recently suffered from alcoholism for 33 years and is diagnosed with liver cirrhosis.**	**1. Carry out procedure measures as ordered to identify and minimize complications.** **2. Provide a non-judge mental attitude towards clients lifestyle choices to promote feelings of self worth. Refer patient too counseling and therapy to address lifestyle choices and risk behaviors. Modifications of behaviors will provide a risk avoidance for drug and alcohol abuse and exposure to body substance pathogen infection.**	**1. Patient follows the prescribed treatment planned and verbalizes the impact of contaminants and exposure to chemicals on one's health.**	**The patient was able to follow the instructions and information. The patient was a previous alcoholic but stated he has not drank since January 2022. The nurses main goal is to ensure that the patient understands the critical condition their body can be in due to this alcohol and drug use.**

Other References (APA):

Phelps, Linda Lee. *Nursing Diagnosis Reference Manual*. (2020) Eleventh Edition. Sparks and Taylor's, Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
Current smoker, Stopped drinking January 2022.
Divorced
Pain level= 0
Allergic to cat dander
Nursing Diagnosis/Outcomes
1.) Risk for deficient fluid volume related to hematemesis as evidence by constant vomit with blood in a coffee ground appearance.
2.) Risk for bowel incontinence due to taking laxatives as evidenced by future colonoscopy.
3.) Risk for impaired liver function due to substance misuse as evidence by liver cirrhosis.
Objective Data
BMI:25.71
Height: 5'9'' Weight: 79kg
Past medical history: Alcoholism (2017), Cocaine abuse (2018), Liver damage, Sleep apnea.
Vital Signs: BP- 123/63 Pulse- 66 Resp- 16 Temp- 97.7 SaO2- 97%
Client Information
Age: 57
White male
Admission date: 6/4/2022
CC: Hematemesis
Left leg amputee below knee
Nursing Interventions
Monitor and record vital signs every two hours or as often as necessary until stable. Then monitor and record vital signs every four hours. Tachycardia, dyspnea, and hypotension may indicate fluid volume deficit or an electrolyte in balance. (Rest are below)

Nursing interventions:

2. Measure and take an output every 1 to 4 hours. Record and report significant changes. Include urine, stools, vomitus, wound drainage, nasogastric drainage, chest tube drainage, and any other output. Low urine output and high specific gravity indicate hypovolemia.

3. Establishing a routine time for him to get up and use the bathroom.

4. Encouraging the client to be aware and responsive to possible incontinent episodes and the acceptance of the bowel movement routine.

5. Carry out procedure measures as ordered to identify and minimize complications.

6. Provide a non-judgemental attitude towards clients' lifestyle choices to promote feelings of self-worth. Refer patient to counseling and therapy to address lifestyle choices and risk behaviors. Modifications of behaviors will provide a risk avoidance for drug and alcohol abuse and exposure to body substance pathogen infection.